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ABSTRACT

A 1975 Dartmouth Outward Bound Mental Health Project, begun with a pilot project for disturbed adolescents, has evolved into an ongoing treatment option in three separate clinical settings for psychiatric patients and recovering alcoholics. Outward Bound consists of a series of prescribed physical and social tasks where the presence of stress, uncertainty, and the need for problem solving, communications, and immediate judgment provide situational analogues for problematic areas in the patient's daily life. The Outward Bound session consists of traditional activities such as individual and group problems solving activities, ropes course, rock climbing, hiking, orienteering, canoeing, and cross-country skiing. Patients in the diagnostic categories of schizophrenia, mood disorders, neurotic and personality disorders, alcohol and drug abuse, and adjustment disorders have participated in the program conducted by a treatment team consisting of an attending physician, resident physician, nursing staff, social service, and activity therapy staff. Follow-up studies of participating patients indicate that Outward Bound was a very positive experience which increased patients' self-esteem. These studies support the postulates that performance accomplishments are an influential source of information and that, when perceived to be of great magnitude, these accomplishments tend to be generalized to other situations in which performance had formerly been inhibited due to feelings of personal inadequacy. (NEC)

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OUTWARD BOUND: AN INNOVATIVE PATIENT EDUCATION PROGRAM

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ABSTRACT

The authors report on the use of Outward Bound activities in a mental health setting. They provide a theoretical framework within which to conceptualize the learning process as well as descriptive information on a model treatment program for psychiatric patients and recovering alcoholics. The authors conclude their article with a discussion of the pertinent issues on conducting an experience as well as integrating the program into both a comprehensive medical center and an alcohol rehabilitation hospital.

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OUTWARD BOUND: AN INNOVATIVE PATIENT EDUCATION PROGRAM

BACKGROUND

Learning theory is well established in providing strategies for dealing with issues of illness (Fordyce 1976; Wooley 1978). Concepts of performance-based learning (Bandura 1975, 1977) have added substantially to the efficacy of delivering educational material in experiential settings. Similar to academic material which is delivered in relevant experiential settings (Jernstedt 1980), patient education programs can address clinically relevant issues in experiential settings. The purpose of the experiential component is to provide a planned experience, in a prescribed environment, that will serve as resource material (a metaphor) for the cognitive content of the program.

The experiential program described in this article is delivered in the context of the Outward Bound model. Outward Bound is an experiential education institution which promotes self-growth through wilderness challenge. It operates on the assumption that individual self-esteem grows with the successful completion of seemingly difficult tasks. Outward Bound takes its roots in the educational philosophy of its founder, Kurt Hahn. Hahn composed his curriculum from the philosophy of some of his contemporaries. Notably, William James, the psychologist, wrote an essay entitled, "The Moral Equivalent of War." Hahn was intrigued by the possibility of creating a program using the positive by-products of war, namely physical preparedness, discipline, teamwork, a sense of loyalty to a cause, and ex-

tending oneself on behalf of that cause. He felt that if he could capture those dimensions, and harness them toward a peaceful end rather than a destructive end, it would be good for society.

During World War II, Hahn was commissioned by the British Merchant Navy to develop a training program for young British seamen. During the early years of the War, when German U-Boats were torpedoing British Merchant ships, an interesting and ironic pattern emerged. While the young, more physically fit seamen were not surviving the hardships of a disaster at sea, the older, less fit seamen were able to endure. Hahn found that the older seamen's prior life experience enabled them to persevere, while the younger seamen, lacking experience, did not have the tenacity to cope and simply gave up their will to live. The program trained young men to handle themselves in adversity, by subjecting them to a series of physically challenging, and psychologically demanding tests in supervised but seemingly hostile and threatening situations. The program was so successful that after the war, Outward Bound spread throughout the world (26 countries) and came to America in 1962. Since then the five American schools have been adapting Outward Bound to various populations.

PSYCHIATRIC APPLICATIONS

Outward Bound consists of a series of prescribed physical and social tasks, where the presence of stress, uncertainty and the need for problem solving, communications, and immediate judgment provide situational analogues for problematic areas in the patient's daily life.

Three characteristics of the Outward Bound process commend its

use in working with psychiatric patients. Outward Bound consists of a series of progressively challenging problems with the following features:

1. The tasks are inherently concrete, manageable, and solvable within a limited time frame. Although initially the problems posed may appear to be overwhelming, when approached in a systematic manner thay are, indeed, geared for success.
2. Mastery of the skill provides participants with a sense of accomplishment. It builds on one's strengths and reinforces positive aspects rather than highlighting failures and weaknesses. In this sense it focuses on the healthier, functioning part of the individual. The complexity and difficulty of the challenges corresponds to incremental levels of instructions. By performing a needs assessment of the group, the instructor determines the starting-off point and developmental sequence of the activities which increases the probability of success.
3. The supportive climate created by the instructor and the peer group as well as the interaction generated by addressing specific tasks, allows conflicts, anxieties, and difficulties to be dealt with openly and examined in a straight-forward manner.

OUTWARD BOUND: A THEORETICAL FRAMEWORK

Social Learning Theory as developed by Bandura (1977) explains the Outward Bound process well. Social Learning Theory contends that individuals not only change their behavior as a

result of reinforcement, but that individuals also modify their behavior as a result of interactions with others who are systematically reinforced. Bandura (1975) developed a number of techniques that utilize the priniciple of vicarious reinforcement, collectively known as "modeling."

Bandura proposes that psychological procedures work by altering the level and strength of an individual's sense of self-efficacy. Self-efficacy is highly related to treatment compliance and motivational issues since it addresses the conviction that one can successfully execute the behavior required to produce the anticipated or desired outcome. Expectations of personal efficacy determine whether coping behavior will be initiatied, how much effort will be expended, and how long it will be sustained in the face of obstacles and adverse experiences. Efficacy expectations vary according to magnitude of the task, degree of generalization to new tasks and their persistence in the face of disconfirming experiences.

In summarizing his theory, Bandura states that....

> "Current developments in the field of behavioral change reflect two major devergent trends...On the one hand, the mechanisms by which human behavior is acquired and regulated are increasingly formulated in terms of cognitive processes. On the other hand, it is performance-based procedures that are proving to be most powerful for effective psychological changes. As a consequence, successful performance is replacing symbolically based

experiences as the principal vehicle of change.

> The apparent divergence of theory and practice can be reconciled by postulating that cognitive processes mediate change but that cognitive events are induced and altered most readily by experience of mastery arising from effective performance (1977).

According to Bandura, efficacy expectations are derived from four sources:

A. Performance Accomplishments

B. Vicarious Experience

C. Verbal Persuasion

D. Emotional Arousal

Outward Bound exemplifies Bandura'a theory by presenting individuals and groups with apparently impossible or difficult tasks and then providing the specific skills, information, emotional support and the Outward Bound Interventions to accomplish those tasks. The Outward Bound Interventions consist of the following:

1. Performance Accomplishments
   a. Having people learn by direct experience
   b. Modeling
      Staff demonstrate ---patients attempt tasks---
      first assertive patients ---then timid patients
      follow
   c. Performance desensitization occurs through
      accomplishing high risk activities and group
      interactions

d. Performance exposure occurs through observation of others participating in high risk activities and group interactions

II. Vicarious Experience

a. Individuals learn about themselves while watching others in stressful situations

b. Live modeling by instructor and others

c. Symbolic modeling through group discussions where individuals discuss personal problems and consider alternatives

III. Verbal Persuasion

a. Suggestion--staff and peers instruct and suggest new behaviors

b. Interpretive Treatment--staff and peers "interpret" patient's successes as examples of "what they can do if they try," etc.

IV. Emotional Arousal

a. Seeing others succeed, and then succeeding oneself causes one to feel more capable

b. Combining enough arousal to motivate but not so much as to cause fear and avoidance of the situation

V. Group Support

Outward Bound represents a social environment that promotes individual decision-making which at the same time has the support of a peer group; that is, individuality within a cooperative framework.

VI. Mastery

Outward Bound tasks are designed to insure a gradual decline in anxiety and maximize the probability of success. Activities with a specific starting point and sequence are selected after a comprehensive needs assessment. Mastery is achieved by translating one's attitude and newly acquired skills into effective performance.

THE OUTWARD BOUND MENTAL HEALTH PROJECT

The Outward Bound Mental Health Project began in 1975 with a pilot project for disturbed adolescents (Kistler, et.al. 1977). Since then the Project has evolved into an on-going treatment option in three separate clinical settings. The Outward Bound session consists of traditional activities such as individual and group problem solving activities, ropes course, rock climbing, hiking, orienteering, canoeing and cross-country skiing.

CLINICAL SETTINGS

The Dartmouth-Hitchcock Mental Health Center, a component of the Mary Hitchcock Memorial Hospital, is a 30-bed unit which admits patients of all ages and all diagnostic categories. The objectives of the in-patient unit include crisis intervention, diagnosis, stabilization, and the initiation of short-term therapeutic intervention. The average length of stay is three weeks. One-day Outward Bound experiences are offered in conjunction with short-term therapy.

The second setting is at the Veterans Administration Hospital

in White River Junction, Vermont. Patients for this program are drawn from two separate populations, the 20-bed short-term diagnostic in-patient unit, and the Alcohol Rehabilitation Program, a 28 day residential treatment program. The experiences at the V.A. are day long and occur on a weekly basis. The Dartmouth-Hitchcock Mental Health Center and the V.A. are both in psychiatric units of teaching hospitals, under the auspices of the Department of Psychiatry, Dartmouth Medical School.

The third setting is Beech Hill Hospital, a 28-day alcohol rehabilitation hospital. Again the experiences are day long and occur on a weekly basis.

Patient Selection

A review of the patients to determine who might benefit from Outward Bound is conducted by the treatment team. The treatment team, consisting of an attending physician, resident physician, nursing staff, social service, and activity therapy staff, establish treatment goals and monitor patient progress. After discussing relevant goals and medical considerations, the final recommendation for a patient to participate in Outward Bound is written in the patient's chart by the resident physician. At this time, the patient is invited to participate and he/she attends a pre-meeting to be introduced to Outward Bound.

Following a description of what they might expect on Outward Bound, patients establish goals in the pre-meeting. Common themes include coping with anxiety, establishing trust and cooperation, assuming responsibility for self and other, completing tasks, commu-

nicating more effectively, learning a new skill; or simply having fun. Goals tend to vary from the concrete to the abstract, depending on one's degree of illness, insight and capacity to generalize. It is sometimes difficult for patients who are coming on their initial experience to set relevant goals, particularly if they are not familiar with Outward Bound. Many patients attend more than one experience. The more they participate in Outward Bound the easier it is for them to see the relevance of Outward Bound as a therapeutic experience and thus to establish realistic goals for themselves. The experience becomes a metaphor for issues faced on the ward and at home. Occasionally, patients who are familiar with each other are able to help each other set goals. Interactions of this sort can be particularly therapeutic for patients.

Periodically, patients attend the pre-meeting and refuse to participate in the actual Outward Bound experience. This resistance, avoidance, or lack of perceived relevance. then becomes a focal point for subsequent therapy. In other words, we can learn and add to the data base from a patient who refuses the experience.

Eligibility

The program has included patients in the following diagnostic categories: schizophrenia, mood disorders, neurotic and personality disorders, alcohol and drug abuse, and adjustment disorders. Patients for whom Outward Bound is contra-indicated are as follows: acutely psychotic patients; extremely manic patients; patients undergoing a course of ECT (Electroconvulsive therapy); medical or medication risks; patients too significantly handicapped by age and/or

disability; impulsive persons with tenuous self-control (suicidal, homocidal, combative); severe seizure disorders; and serverely organically impaired patients.

We have found that an evaluation of psychosocial dysfunction is a more important programmatic determinant than diagnostic category. The perceived relevance of the potential benefits from an Outward Bound program and the ability to see the experience as a metaphorical event appear to be most important. The significance of the patient's attributions to motivational and relevance issues is well documented in social psychology literature (Kelley 1967).

STAFF AND CLINICAL ISSUES

From a clinical standpoint, the staff view Outward Bound as a continuum of experience rather than as an isolated activity. That is, it is part of an ongoing treatment process. Our experience supports Ridway and Fidler's (1959) contention that activity alone cannot accomplish the therapeutic objectives established in a treatment plan. They consider activity not as an end in itself but as a means to the establishment of meaningful relationships with others, which is the core of treatment. In order to maximize the integration of the experience with relevant material from ward or home environment, there is both an Outward Bound instructor and a therapist present.

During a single experience, one is exposed to extremes of emotion--from a panic attack to elation and exhilaration. Many patients comment on how they perceive having to take responsibility for themselves and others during Outward Bound. This occurs in

a very real and consequential environment and is in distinction from more benign encounters within the protective environment of the hospital. Thus, a patient's behavior on Outward Bound may be quite different from what is exhibited on the ward. In this sense, the patient's direct experience provides the substance of direct observation from which therapeutic inferences can be drawn. For example, our clinical experience corroborates Newman's (1980) hypothesis that providing opportunities for the development of a sense of competence and for the questioning and altering of unrealistic attributions and expectations should aid in addressing the issue of learned helplessness. Outward Bound tasks, for instance, are designed to address the patient's attributions regarding the causes of success and failure. We then draw a metaphor from the response to the program and relate it to other dilemmas in daily living tasks. As Covington (1976) points out, when an individual works on a task within his reach, degree of effort becomes the overriding determinant of success (or failure). Reinforcing the causal link between personal effort and outcome helps combat a sense of learned helplessness.

Processing the experience with patients generally occurs in two ways. One is to have a focused discussion after each activity. The most appropriate time to educate the patient regarding those cognitive and interpersonal factors which are relevant is as situations are being confronted. Further, helping the patient to discriminate and properly label his anxiety is a valuable first step in problem solving, whether the participant needs to relax,

address negative thoughts, feelings or images, or interact and communicate on an interpersonal level. Helping the group to see the relevance of self disclosure, listening, and providing feedback for each other is important. Further, the therapist and instructor have the opportunity to model appropriate social skills. The impact of such skills on problem solving, anxiety resolution, and team functioning is immediately apparent with the task at hand. See Table 1.

The second format is to have a group discussion at the end of the day. Here we focus on individual patient's objectives, thoughts, and feelings about the day in general. We also give specific feedback to each other. In this context the Outward Bound experience is used--as a metaphor--to create the content for a verbal group therapy session. Mack and Barnum (1966) argue that activity combined with verbal group therapy succeeds in deepening the therapeutic impact of hospitalization. Their findings reveal that a wide range of significant issues were discussed in the group: closer relationships were developed with the leader, and with group members; greater ward cohesion resulted; and work and recreation became more gratifying.

Reporting

Reporting on the field experience includes staff observations, the patients' understanding of their psychological difficulties, and their ability to generalize from the field experience to other relevant therapeutic issues. As mentioned previously, diagnostic and evaluative data concerning patients is often valuable information for the treatment team.

Example 1: Carl, a 20 year old male patient with a presenting problem of episodic dyscontrol, particularly in relation to his wife from whom he was being divorced, was referred to Outward Bound for evaluation of his interactive style as well as offering a successful experience in surmounting environmental obstacles. On his first experience he was observed to have unusual difficulty learning and performing a kickturn while on cross-country skis. During his second experience he had extreme difficulty in positioning and controlling his body while on the ropes course. In fact, when he took a secured fall, he did not know exactly where in space his body was.

With this information the treatment team recommended further neuropsychiatric testing which corroborated the information gleaned on Outward Bound; i.e. beyond the presenting problem this young man had an underlying sensory integration deficiency as well as Attention Deficit Disorder. Thus Outward Bound provided diagnostic/evaluative information that led to further testing and a revision of his treatment plan.

Example 2: Note writing format (SOAP).

Subjective: The patient's description of the experience.
E.g., "I wasn't at all scared while rock climbing."

Objective: What the staff observed.
E.g., The patient was unusually anxious while rock climbing.

Assessment: The staff's inference about the subjective and objective data.

E.g., The patient uses denial as a defense mechanism.

Plan: What the staff is going to do or wants others to do in the future. This includes "observe for...," "teach about...," "consult with...," e.g., the issue of denial needs to be addressed in individual therapy. as well as in other activities, including future Outward Bound trips.

As a therapeutic agent, it is our responsibility to process the data and help the patient become aware of his affective state as observed. For instance, while rock climbing, he was experiencing shortness of breath, profuse sweating, etc., and this state is incongruent with his self-reported view of himself as being "cool, calm, and collected" at confronting the rock climb. This is highly relevant information from which the patient can learn about himself, and when conveyed to the staff can be made relevant to other treatment processes.

RESEARCH

Plakun, Tucker, and Harris (1981) studied fifty-two consecutive patients to participate in the Dartmouth-Hitchcock Mental Health Center program in order to assess their expectations of improving their coping abilities as a result of Outward Bound. Patients completed a questionnaire before and after their initial experience, and the information gathered was compared to demographic, diagnostic and personality data. Their report

suggests that Outward Bound successes provided relief from a pervasive sense of an inability to cope and low self-esteem.

In 1979 the Project sent out follow-up questionnaires to all patients who participated in the Dartmouth-Hitchcock Mental Health Center program for that year. The rate of return of these questionnaires was approximately forty-five percent. Of that group of respondents, a majority reported that Outward Bound was a very positive experience which increased their self-esteem. Most of this group also reported that they have thought many times about their experience since leaving the hospital. Some comments:

"Almost every week I think of the experience of climbing to the top of the rock. I still can't believe I did it."

"When telling friends about what a satisfying experience my hospital stay was. And other times when I am doing something that is emotionally or physically hard."

"At least twice a week. And if I am sitting trying to figure something out. It was fun."

"Being able to speak in a group without my feeling that no one wanted to hear what I had to say. I have a lot more self confidence."

These findings support two important postulates of Bandura's Social Learning Theory. First, performance accomplishments are

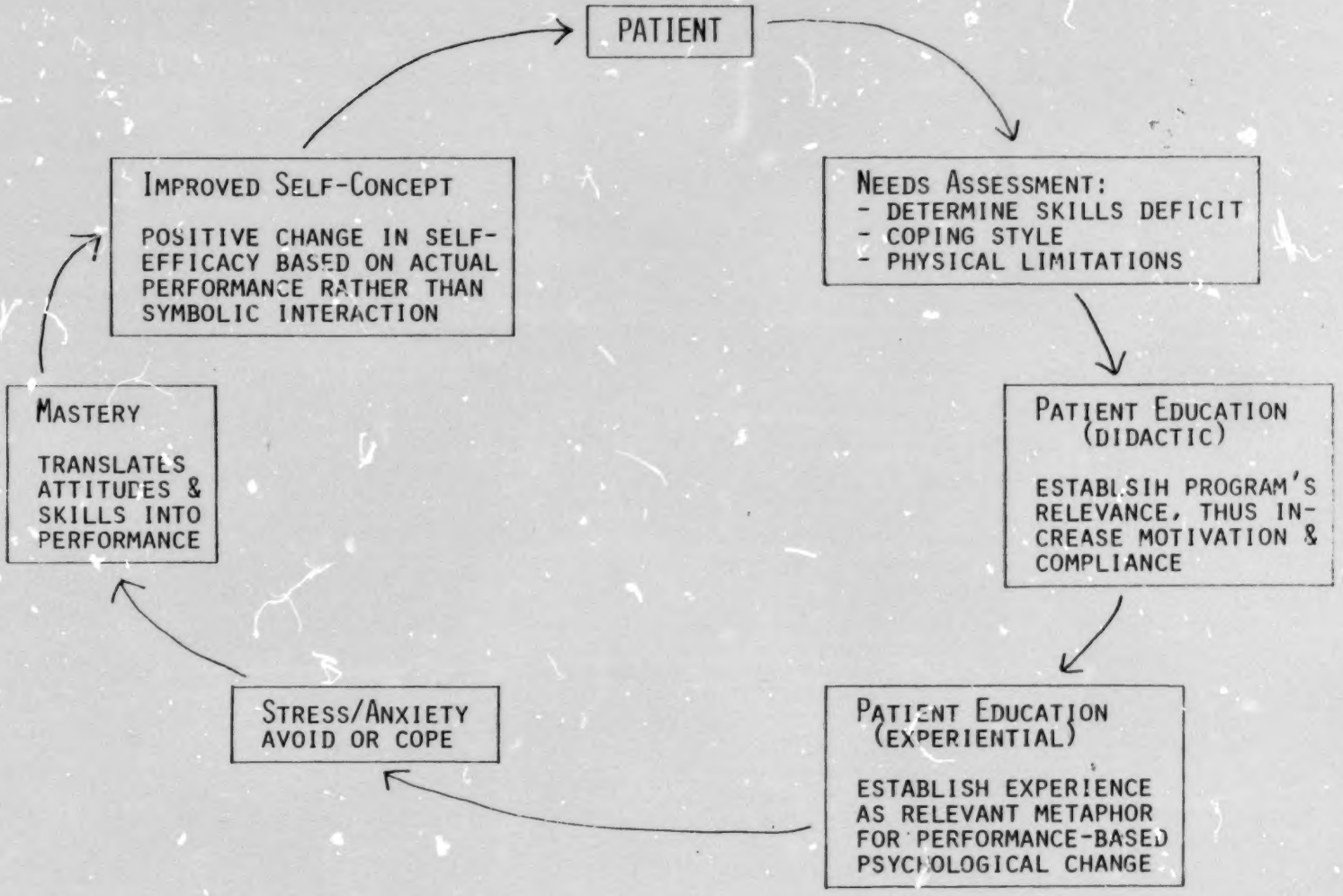
an influential source of information since they are based on personal mastery experiences. And secondly, when performance accomplishments are perceived to be of great magnitude, they tend to be broadly generalized to other situations in which performance had formerly been inhibited due to feelings of personal inadequacy.

SUMMARY

In conclusion, this article has been an attempt to elucidate the nature and rationale of using Outward Bound as a day-long activity for psychiatric patients and recovering alcoholics. The purpose of the Dartmouth Outward Bound Mental Health Project is to develop a unique patient education program that utilizes not only traditional concepts of patient educaiton but also techniques of performance-based psychological change.

Within the context of a mental health setting, a 6-8 hour period of time for one sustained therapeutic endeavor is, indeed, an unusually large block of time. We believe that this Project stands as an example of how positive outcomes in treatment objectives can occur as well as how important diagnostic/evaulative information can be derived.

COMBINED DIDACTIC/EXPERIENTIAL THERAPY PROCESS SCHEMA


PATIENT
NEEDS ASSESSMENT:
- DETERMINE SKILLS DEFICIT
- COPING STYLE
- PHYSICAL LIMITATIONS
PATIENT EDUCATION (DIDACTIC)
ESTABLSIH PROGRAM'S RELEVANCE, THUS INCREASE MOTIVATION & COMPLIANCE
PATIENT EDUCATION (EXPERIENTIAL)
ESTABLISH EXPERIENCE AS RELEVANT METAPHOR FOR PERFORMANCE-BASED PSYCHOLOGICAL CHANGE
STRESS/ANXIETY AVOID OR COPE
MASTERY
TRANSLATES ATTITUDES & SKILLS INTO PERFORMANCE
IMPROVED SELF-CONCEPT
POSITIVE CHANGE IN SELF-EFFICACY BASED ON ACTUAL PERFORMANCE RATHER THAN SYMBOLIC INTERACTION

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